



Authorization Request Form

Neuro/Psychological Testing

An intake evaluation must be completed before a request for testing will be considered. Testing for learning disability, attention deficit disorders and disability evaluations is not covered. Rating scales, checklists, inventories and questionnaires are not reimbursed as testing.

Patient's Name: _____ DOB: ____ / ____ / ____ ID# _____

***Please attach a copy of the psychological intake and fax all to 608-245-3097 .**

Diagnosis Code(s):

Has the patient had previous testing? Yes No
If yes, when? ____ / ____ / ____

What specific questions will be answered by the evaluation?

1. _____
2. _____
3. _____

Describe how the evaluation will help to implement the treatment plan:

Describe what other strategies/treatments have failed:

Specify the proposed measures and rationale for use:

Measure Name: _____ CPT Code: _____ Hours: _____

Rationale: _____

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Rationale: _____

Measure Name: _____ CPT Code: _____ Hours: _____

Rationale: _____

Measure Name: _____ CPT Code: _____ Hours: _____

Rationale: _____

Provider Name: _____

Facility Name: _____ NPI: _____

Address: _____ Tax ID: _____

Contact Name: _____ Phone: _____ Fax: _____

The submission of supporting clinical documentation/plan of care is required with this form.

Privacy and Confidentiality:

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